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INFORMATIONAL NOTICE

TO: Participating Medical Assistance Providers

RE: Clarification on Billing Requirements for Diagnostic Services

In an informational notice issued by the department in early July, providers were informed of various billing changes related to diagnostic services. This notice rescinds information contained in the July 2004, notice, **in accordance with the American Medical Association guidelines**, as well as reiterates the department's billing requirements as they relate to billing for technical or professional components only.

The department will no longer require **providers** to bill both modifiers TC and 26 for global reimbursement of diagnostic services. Effective with claims submitted on or after September 1, 2004, the department will pay a global reimbursement for diagnostic procedure codes submitted without a modifier. Claims submitted for reimbursement of the technical or professional component only **must** contain the procedure code and modifier 26 or TC, as applicable.

If the claim is incorrectly billed for a global reimbursement, when it should have been billed for one of the two service components (technical only or professional only) it will be the responsibility of the service provider to correct the error. Providers who received reimbursement for the global fee, instead of the technical or professional only, should **complete an adjustment form to void the incorrect claim and resubmit a new claim for payment reconsideration**. This will allow each provider to bill and receive payment for the service actually provided and will prevent an audit finding.

Questions regarding this notice should be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

Anne Marie Murphy, Ph.D.
Administrator
Division of Medical Programs